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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/19/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155568	A. BUILDING 01 B. WING _____	01/11/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERS OF WILLIAMSPORT, THE	200 SHORT ST WILLIAMSPORT, IN 47993

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 01/11/11 Facility Number: 000449 Provider Number: 155568 AIM Number: 100290350 Surveyor: Bridget Brown, Life Safety Code Specialist At this Life Safety Code survey, The Waters of Williamsport was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type II (000) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, resident rooms and spaces open to the corridors. The facility has a capacity of 96 and had a census of 56 at the time of this survey. Quality Review by Robert Booher, REHS, Life Safety Code Specialist-Medical Surveyor on 01/18/11. The facility was found not in compliance with the aforementioned requirements as evidenced by:	K 000	**Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admission or agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws.**	
K 021	NFPA 101 LIFE SAFETY CODE STANDARD	K 021		

APPROVED
2/3/11 DF

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

See attached — 2-2-11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

the waters™
of Williamsport
A Rehabilitation & Skilled Nursing Center
Recuperate • Rejuvenate • Rehabilitate

February 2, 2011

Indiana State Department of Health
2 North Meridian Street
Indianapolis, Indiana 46204

ATTN: Ms. Kim Rhoades, Director
Long Term Care Division

RE: Survey Event ID OXBV21

Dear Ms. Rhoades:

Enclosed is our plan of correction (POC) for survey conducted January 11, 2011. By submitting the enclosed materials we are not admitting the truth or accuracy of any specific findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations.

Sincerely,

Gloria J. McGowen

Gloria J. McGowen, CEO

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K 021 SS=E	Continued From page 1 Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure is held open only by devices arranged to automatically close all such doors by zone or throughout the facility upon activation of: a) the required manual fire alarm system; b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and c) the automatic sprinkler system, if installed. 19.2.2.2.6, 7.2.1.8.2 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure 1 of 5 smoke barrier door sets was held open by a device which would allow the doors to close upon activation of the fire alarm system. LSC 8.3.4.1 requires doors in smoke barriers shall close the opening leaving only the minimum clearance necessary for proper operation which is defined as 1/8 inch. This deficient practice could affect visitors, staff and 20 or more residents in the C wing, D wing, and center smoke compartments. Findings include: Based on observation with the maintenance director and vice president of operations on	K 021	**K021** It is the intent of this facility to ensure the smoke barrier door automatically closes upon activation. **I. Actions taken for the residents identified:** There were no specific Residents identified on the 2567 to be affected. **II. How other residents were identified:** No other Residents were identified as being affected. **III. Systems in place:** The smoke barrier door coordinator has been adjusted to meet standards. **IV. How the actions will be monitored and what Quality Assurance Program will be in place:** The Maintenance Supervisor will monitor the smoke barrier door monthly as part of his monthly preventative maintenance program.	

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K 021	Continued From page 2 01/11/11 between 12:10 p.m. and 3:35 p.m., the west smoke barrier door set was held open by a device, a door coordinator, and failed to close when tested twice with the maintenance director. The doors gapped six inches when one of the doors in the door set hit the door coordinator and failed to close. The doors failed to close again when the fire alarm was tested. The maintenance director said at the time of observations, the coordinator needed adjusting to work properly. 3.1-19(b)	K 021	**V. Date of completion:** This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 2/10/11.	
K 076 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure 1 of 1 oxygen supply storage rooms was enclosed by a one hour fire rated construction. NFPA 99, 8-3.1.11.1 requires storage for nonflammable gases shall comply with 4-3.1.2. NFPA 99, 4-3.1.1.2(a)2 requires at least one hour fire resistant enclosures shall be	K 076	**K076** **It is the intent of this facility to ensure that medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities.** **I. Action taken for the Residents Identified:** There were no specific Residents identified on the 2567 to be affected. **II. How other Residents were identified:** No other Residents were identified as being affected.	

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K 076	Continued From page 3 provided for the storage of oxidizing agents such as oxygen. This deficient practice could affect visitors, staff and an undetermined number of residents in the center smoke compartment where the main dining room is located. Findings include: Based on observation with the maintenance director and vice president of operations on 01/11/11 at 2:00 p.m., the oxygen storage room which contained six, 181 liter capacity liquid oxygen tanks and four e-cylinders was located in a room accessed by a door outside the service corridor exit. The five by five foot concrete walls stopped approximately four inches from the ceiling. Two of the walls were a part of the adjacent kitchen wall construction. The four inch space between the ceiling and walls was sealed with exposed pink fiberglass insulation in the oxygen room and concealed by the laid in ceiling in the kitchen. The maintenance director agreed at the time of observation, the construction of the enclosure could not provide a fire resistance of one hour.	K 076	**III. Systems in place:** The ceiling in the oxygen room has been repaired with fire rated drywall to meet set standards. **IV. How the actions will be monitored and what Quality Assurance Program will be in place:** The Maintenance Supervisor will inspect the ceiling monthly as part of his Preventative Maintenance Program. **V. Date of completion:** This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 2/10/11.	
K 103 SS=E	3.1-19(b) NFPA 101 LIFE SAFETY CODE STANDARD Interior walls and partitions in buildings of Type I or Type II construction are noncombustible or limited-combustible materials. 19.1.6.3 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure the construction of 1 of 1 walls in	K 103	**K103** **It is the intent of this facility to ensure that interior walls and partitions of Type I or Type II construction are noncombustible or limited-combustible material.**	

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K 103	Continued From page 4 the center smoke compartment in this building of Type II construction was built with noncombustible or limited combustible materials. This deficient practice affects staff, visitors and an undetermined number of residents in the center smoke compartment where the main dining room is located. Findings include: Based on observation with the maintenance director and vice president of operations on 01/11/11 at 1:25 p.m., a wall partition in the laundry room was constructed of combustible wood studs and drywall. Only one side of the partition was finished with drywall leaving the untreated wood studs exposed. The maintenance director said at the time of observation, the partition construction was finished as is. 3.1-(19)b	K 103	**I. Action taken for the Residents identified:** There were no specific Residents identified on the 2567 to be affected. **II. How other Residents were identified:** No other Residents were identified as being affected **III. Systems in place:** Fire rated drywall was installed on the back side of wall partition in the laundry room to meet set standards. **IV. How the actions will be monitored and what Quality Assurance Program will be in place:** The Maintenance Supervisor will monitor monthly as part of his Preventative Maintenance Program. **V. Date of completion:** This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 2/10/11.	